

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 675935	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
NAME OF PROVIDER OR SUPPLIER Life Care Center of Haltom		STREET ADDRESS, CITY, STATE, ZIP CODE 2936 Markum Dr Fort Worth, TX 76117	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents fed by enteral means received the appropriate treatment and services to prevent complications of enteral feedings for 1 of 1 resident (Resident #13) reviewed for enteral nutrition. The facility failed to include Resident #13's down time in the physician orders for enteral feeding. The facility failed to include Resident #13's down time from enteral feeding on her Medication Administration Record. These failures could affect residents receiving enteral nutrition/hydration and place them at risk of health complications and decline in nutrition. Findings included: Record review of Resident #13's Quarterly MDS dated [DATE] revealed the resident was a [AGE] year-old female originally admitted on [DATE] and readmitted on [DATE]. Resident BIMS score was 00 (which indicates severe thinking and cognitive function). Resident #13's cognitive skills for daily decision making indicated severely impaired. The assessment reflected Resident #13's diagnoses included diabetes mellitus (a disorder of carbohydrate metabolism marked by impaired ability to produce or respond to insulin and maintain blood glucose levels), malnutrition (the condition that develops when the body does not get the right amount of the vitamins, minerals, and other nutrients it needs to maintain healthy tissue and organ function). The MDS reflected Resident #13 received her nutrition via tube feeding. Record review of Resident #13's undated care plan revealed the following: Resident #13 requires tube feeding related to Dysphagia (difficulty swallowing) and is at risk for complications related to placement. Goal: The resident will remain free of side effects or complications related to tube feeding. The resident will maintain adequate nutritional and hydration status and weight stable, no signs or symptoms of malnutrition or dehydration. The resident will be free of aspiration (fluid or solid enter the airways or lungs, leading to airway blockage or pneumonia). Interventions included resident needs the head of bed elevated 45 degrees during and thirty minutes after tube feed. Observe and report as needed any signs or symptoms of: Aspiration- fever, short of breath, Tube dislodged, Infection at tube site, Self-extubation (removing their own tubing), Tube dysfunction or malfunction, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension (enlarged/bloated), tenderness, Constipation or fecal impaction, Diarrhea, Nausea/vomiting, Dehydration. Registered Dietician to evaluate quarterly and as needed. Make recommendations for changes to tube feeding as needed. Record review of Resident #13's physician orders included the following: 1. NPO diet NPO texture, NPO consistency Active with start date: 10/16/252. Enteral Feed Order as needed Enteral access site care; verify tube securement is in place Active with start date: 10/17/253. Enteral Feed Order as needed Verify position of Enteral Access Device prior to feeding/medication administration, compare documented length or numerical marking at the exit site to the previously documented length. If changes have occurred/ concern for migration, contact provider Active with start date 10/16/254. Enteral Feed Order every 4 hours Verify position of Enteral Access Device by comparing the documented length or numerical marking at the exit site of the device to the previously documented length. If changes have occurred and concern for migration exist, contact provider. Active with start date 10/16/255. Enteral Feed Order every day shift Assess the tube exit site for new or increasing pain and signs of skin breakdown, redness, edema (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(fluid trapped in tissues that cause swelling) , leakage, induration (thickening of soft tissue), bleeding, and wear and tear. Active with start date 10/17/256. Enteral Feed Order every day shift Enteral access site care; verify tube securement is in place. Active with start date 10/17/257. Enteral Feed Order every shift At least 15 ml purified water flush before and after medication administration. Active with start date 10/16/258. Enteral Feed Order every shift Glucerna 1.5 at 55ml/hour x 22 hours via pump for a total amount of 1200 ml. Flush with 125 ml purified water every 4 hours. Active with start date 11/06/259. Enteral Feed Order every shift Head of bed elevated at least 30 degrees. Active with start date 10/16/2510. Enteral Feed Order every shift If PEG tube bumper not snugly against the skin, hold tube firmly with one hand and slide the bumper against the ABD with the other. DO NOT place bumper too tightly against skin as it will result in skin breakdown. Active with start date 10/16/2511. Enteral Feed Order every shift Verify position of external bumper on PEG tube. Bumper to remain snugly flush against ABD with dry slit gauze placed underneath. Active with start date 10/16/25Record review of Resident #13's January 2026 MAR did not reflect any down time for the tube feedings. Observations on 01/13/26 from 10:00 AM-12:00 PM, of Resident #13 revealed she was disconnected from the feeding pump, which meant the formula was not infusing. Observations on 01/14/26 from 10:00 AM-12:00 PM, of Resident #13 revealed she was disconnected from the feeding pump, which meant the formula was not infusing. Observations on 01/15/26 from 10:00 AM-12:00 PM, of Resident #13 revealed she was disconnected from the feeding pump, which meant the formula was not infusing. Interview on 01/15/26 at 12:47 PM with RN C revealed she worked morning shift with Resident #13. RN C stated Resident #13 was on 22 hours of continuous tube feedings, and the resident received Glucerna 1.5, 125 flush of water every 4 hours. RN C stated Resident #13 was disconnected at 10:00 AM and reconnected at 12:00 PM to give her a break from the machine and to aide with digesting the formula. RN C stated she was not able to locate where the order read to disconnect Resident #13 for 2 hours continuously or if the two hours should allow for therapy or incontinent care. RN C stated Resident #13 was previously scheduled for surgery, and the orders may not have carried over upon her return. RN C stated it was the responsibility of the nursing staff to ensure orders were entered upon admission, and the ADON and the DON would audit the orders to ensure all orders were entered correctly. RN C stated not having an understanding of Resident #13's feeding orders placed her at risk of weight loss, hunger, or malnutrition. RN C stated the order should include Resident #13's down time, so that all staff would be aware of her feeding schedule. Interview on 01/15/26 at 1:18 PM with the ADON revealed she knew Resident #13 received Glucerna 1.5 by tube feeding machine for 22 hours continuously. The ADON stated Resident #13 was disconnected for two hours during the morning shift between 10:00 AM until 12:00 PM with RN C. The ADON stated she did not see the order that indicated Resident #13 would disconnect from the machine for 2 hours however RN C was aware to disconnect Resident #13 at that time. She further stated the MAR should alert RN C to do so. The ADON stated she did not see a risk for Resident #13 if her order did not indicate specific details for her down time from her feeding. The ADON stated Resident #13 was on continuous feedings for 22 hours, and it just so happened that Resident #13's down time was with RN C. The ADON stated RN C was very knowledgeable about her hallway and the residents, who resided on the hall. Interview on 01/15/26 at 2:35 PM with the DON revealed Resident #13 was on 22 hours of continuous feeding, with 125 ml flushes of water every 4 hours. The DON stated Resident #13 is doing well with no concerns of weight loss. The DON stated nurses on duty with Resident #13 were expected to record the orders as they come in and follow them. The DON stated if orders did not indicate a down time, nurses should contact the physician to ensure orders were complete and in this case to indicate when the down time was to be completed. The DON stated not having complete orders placed Resident #13 at risk of weight loss. Record review of the facility's Enteral Nutrition Therapy (Continuous) policy, revised 09/03/24, reflected: The facility will provide continuous enteral nutrition therapy in accordance with physician orders and professional standards of practice. Assisted Nutrition and hydration, based on a resident's comprehensive assessment, the facility must ensure (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that a resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals, to meet the needs of each resident for 1 of 6 medication carts (Hall B cart) reviewed for pharmacy services. The facility failed to ensure one bottle of zinc, with an expiration date of November 2025, had been removed from the Hall B medication cart. This failure could place residents at risk of receiving expired medications that were ineffective. Findings included: Observation on 01/14/26 at 12:39 PM of the Hall B MA cart with MA A revealed one bottle of zinc 50 mg (medication to help with zinc deficiency and used to help the body's immune system fight infections and heal wounds) with an expiration date of 11/2025. Interview on 01/14/26 at 12:51 PM with MA A confirmed the zinc expired in November 2025. MA A stated she checked her carts every 2 weeks for expired medications, but she would review the medications daily as well. She stated she just checked for expired medications the previous week, but she did not see the zinc. MA A stated it was all nurse's responsibility to ensure there were no expired medications, but it was her fault since it was her medication cart. MA A stated by failing to remove the expired medication, the medication could be administered, and the dose could cause a reaction. MA A stated she had done training on checking for expired medications and reviewing the carts. Interview on 01/15/26 at 12:50 PM with Facility Physician B revealed the risk of having expired zinc on the medication cart was the medication could be administered, causing an upset stomach, vomiting, and it could affect the effectiveness of the medication. Interview on 01/15/26 at 1:03 PM with The ADON revealed she expected her nurses and medication aides to review the carts every day. She stated the staff should be looking over the medications during administration. The ADON stated she would go behind the staff and look through the medication carts every few days to check to ensure the carts were being reviewed. The ADON stated she checked carts last week and must have accidentally looked at the open date, not the expiration date. She stated she just missed it. The ADON stated the risk of having expired medications on the cart was that they could be administered to residents and not be effective or cause an adverse reaction. The ADON stated she was stepping up to review the medication carts daily and in-servicing on medication administration/carts. The ADON stated it was all the nurse's responsibility to ensure there were no expired medications. Interview on 01/15/26 at 2:37 PM with the DON revealed that she expected her staff to review all their carts daily. The DON stated she also had 3 nurse managers that covered 2 hallways and were monitoring the medication carts weekly and as needed. The DON stated it was the nursing team's responsibility to ensure there were no expired medications on the carts. She stated the risk of not checking the medication carts for expired medications was the medication could be given and not be effective. The DON stated she was providing in-services and education on properly checking for expired medications. Record review of the facility's Storage and Expiration Dating of Medication and Biologicals policy, revised on 06/30/25 reflected the following: .10. Facility should ensure medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier.22. Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications of biological in accordance with pharmacy return/destruction guidelines and other applicable laws. 23. Facility personnel should inspect nursing station storage areas for proper storage compliance on a regular basis.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to collaborate with hospice representatives and coordinate the hospice care planning process for each resident receiving hospice services, to ensure quality of care for the resident, ensuring communication with the hospice medical director, the resident's attending physician, and others participating in the provision of care for 1 of 3 residents (Resident #13) reviewed for hospice services. The facility failed to obtain Resident #13's physician's order for hospice services. This deficient practice could place residents who receive hospice services at-risk of receiving inadequate end-of-life care due to a lack of documentation, coordination of care and communication of resident needs. Findings included: Record review of Resident #13's admission MDS Assessment, dated 10/30/25, reflected she was an [AGE] year-old female who was admitted to the facility on [DATE]. She had a BIMS score of 14 indicating no cognitive impairment. Her active diagnoses included Alzheimer's Disease (progressive mental deterioration that can occur in middle or old age, due to generalized degeneration of the brain) and malnutrition (lack of proper nutrition, caused by not having enough to eat, not eating enough of the right things, or being unable to use the food that one does eat). Her MDS indicated she received hospice care while a resident. Record review of Resident #13's physician's orders, dated 01/14/26, reflected there was not an order for hospice services. Record review of Resident #13's care plan, revised 01/06/26, reflected the following: Focus: [Resident #13] has a terminal prognosis. Interventions: Work cooperatively with hospice team to provide resident's spiritual, emotional, intellectual, physical and social needs. Observation and attempted interview on 01/13/26 at 10:36 AM revealed Resident #13 was asleep in her bed, and the resident did not rouse when spoken to and asked questions. Observation and attempted interview on 01/15/26 at 11:40 AM revealed Resident #13 was asleep in her bed, and the resident did not rouse when spoken to and asked questions. Interview on 01/15/26 at 9:17 AM with LVN B revealed she only worked PRN at the facility, but she knew Resident #13 received hospice services. LVN B said the resident should have an order in her chart for hospice services. She stated the admitting nurse should have included the order in the resident's chart. LVN B said since she was PRN that was all she knew. Interview on 01/15/26 at 2:41 PM with the DON revealed Resident #13 should have had an order to be admitted to hospice in her chart. The DON said usually the nurse, who admitted the resident, would have added it. She stated she chose random charts each week to audit and check for accurate orders. The DON said the purpose of having the order was to make sure everyone was aware the resident was receiving hospice services, so they could communicate with the hospice agency to ensure a collaborative effort and proper care was being provided to the resident. The DON said if the order was missing from the resident's chart, it could potentially cause an issue with her palliative care. Record review of the facility's Hospice Coordination of Care policy, revised 09/03/25, reflected: The facility provides hospice care under a written agreement and must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.		